# **DIOCESE** of **LA CROSSE**



# **EMPLOYEE MEDICAL BENEFIT PLAN GUIDE - Lay Group**

# Plan Year 2024

# **OVERVIEW**

#### Plan Year

o January 1 – December 31, 2024

#### Premiums

- Health Plans
  - Traditional increase of 5%
  - HDHP/HSA increase of 5%
- Dental Plan increase of 5%

### Primary Medical Networks

### Anthem 🗟 🖗

- o www.anthem.com/contact-us/wisconsin/
- o **833.952.2061**

#### Prescription Drug / Pharmacy Benefit

- CVS caremark<sup>®</sup>
- o <u>www.caremark.com/</u>
- o **800-565-7091**

# VSP Vision Plan

#### rsp

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- o vision care Coverage included if enrolled in Health Plan
- Can be added as a separate benefit <u>if not</u> enrolled in a Health Plan
- Member Services - 800-877-7195 or <u>www.vsp.com</u>

# Delta Dental Plan

#### **A DELTA DENTAL**

<u>https://www.deltadentalwi.com/DDWI/s/</u>



# **BENEFIT ELIGIBILITY**



# Eligible Employee:

- Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours).
- Full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours)
- A non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours)

# Additional family members eligible:

- Spouse
- Children, including stepchildren and children placed for adoption with the covered employee, who are up to 26 years old, regardless of student or marital status
- Dependent Children of any age who are disabled or incapable of self support due to physical or mental disability

**PLEASE NOTE:** If you and your spouse are employed within the Diocese of La Crosse and are eligible for the **Diocese of La Crosse Lay Group Employee Medical Benefit Plan**, you can be covered as an employee or as a dependent, but not both. Only one of you can cover your dependents.

The information provided is an outline of the benefits and guidelines of the Diocese of La Crosse Lay Group Employee Medical Benefit Plan and is not intended to be all inclusive. For more information, visit <u>www.StAmbroseFinancial.com</u> – Health Plan - Lay Group.

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	em. 📽 🔍	Di	OCESE OF LA	CROSSE LAY GROU	UP BENEFITS ENROLL	MENT & CHANGE FORM
					SAFS Admin Use Only	Effective Date:
PARISH/INST	ITUTION			City		Group # 1.06588
-	Last Name		First Name	M	Birth Date	Social Security Number
EMPLOYEE	Street Address	City		State Zip	Personal Email	Phone Number
in the second	Single Female					
		Job Title			First Date of Work / First Dat	e of Eligibility Hours / Week
	OF FORM (Must mark one box):					
NEW EMP	LOYEE (Eligible the first of the month	, following First Date o	of Work)			
OPEN EN	COLLMENT (Specific period of time to	enroll or make change	n)			
CHANGE	Termination / Resignation / Ret	firement / Reduction o	of Hours to	Hours / We	ek Last Day of Work	/ Eligibility
	Address – provide new address					
	Name Change New Nam	ne		Forme	r Name	
	Other - personal email, phone r	number, job title				
	Dependent(s)					
	Abb Delete Name			BIRTH DATE	\$5#	RELATION
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	Qualifying Event	alifying Date and the C	halifaine from	A Developer ( Math / )	us of Coverage / Newly Eligit	the Colonna Colon I
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	Deductible	the processing the		Involted WAIVE	L. L. L.	WAIVE
	Insured Name			nce in effect on you or an Gro	ty dependents to be covere sup/Policy #	Effective Date
Dependents Cov	ered					
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	ELECTION			_	_	Dental Employee Family
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	ELECTION D \$30,000 WAIVE If no Primary Beneficiary		ployment, evic	lence of insurability may	y be requested to enroll in Relationship	
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Fax: (608) 787-8068



# To Enroll

The decisions you make at this time can impact your life and finances. It is important to take the time to review and evaluate your options, then complete the **Enrollment - Change Form**.

# When To Enroll

- Open Enrollment Nov. 27 Dec. 14, 2023
- New employees complete the <u>Enrollment Form</u> within 31 days of the employee's first day of work.

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ARISH/INSTITUTION		City		
				Group a Lincolo
Last Name Fi	irst Name	M	Birth Date S	ocial Security Number
INFO Street Address City		State Zip	Personal Email	Phone Number
Single Female		scate zip	Perional Limai	Phone Number
Married Male Job Title		Fire	t Date of Work / First Date of Di	gibility Hours / Week
RPOSE OF FORM (Must mark one box):	(			
IEW EMPLOYEE (Eligible the first of the month, following First Date o				
OPEN ENROLLMENT (Specific period of time to enroll or make changes CHANGE Termination / Resignation / Retirement / Reduction of				
Address – provide new address under employee info	Hours to	Hours / Week	Last Day of Work / Eligi	bility
Name Change New Name		Former N	ame	
Other - personal email, phone number, job title				
ADD Delete Name		BIRTH DATE	\$5#	RELATION
ADD Delete Name		BIRTH DATE	\$5#	RELATION
Qualifying Event State the Qualifying Date and the Q	ualifying Eve	nt Marriage / Brth / Lass /	d Covernae / Newly Elizible / Di	warra / Etc. 1
L / VISION / DENTAL ELECTION - Select elections you are keeping or t				ployee
Employee Plan TRADITIONAL DEDUCTIBLE		Vision Employee		ployee & 1 dependent
dical Family Deductible High Depuctate/HSA		w/Medical Family	Dental Fam	sily
WAIVE		WAIVE	WA	IVE
INSURANCE COVERAGE As of your effective date, will there be a				No Yes
			/Policy #Effe	
Idents Covered Medical	Imployee	Family Vision Emplo	Family Denta	Employee Family
FE / AD& D \$30,000 WAIVE If not elected at start of emp	ployment, ev			e insurance plan.
Primary Beneficiary			ationship	
Contingent Beneficiary	nmunity proper		ationship than your spouse as beneficiary, yo	ou may have your spouse sign
sive higher rights to any community property interest in the benefit. Joyee's spouse, I do hereby consent to the beneficiary designation(s) indicated and w	aive any rights i	may have to the proceeds of such	life insurance under applicable cor	nmunity property laws.
Signature		Dat		
DENT INFORMATION (List all dependents to be covered under this pla Name (Last, First, Middle Initial)	n)*: Sex (M/F)	Birth Date	Social Serv	urity Number
Hanna Francis a sub-second second	and (mpr)			
			_	
al desendents, alease list on next sage				
AL RELEASE / ACCEPTANCE / AUTHORIZATION				
uthorize any doctor, hospital, insurance company, employer, or organization to on and family history, for claims to Diocesan Third Party Administrator. A copy	o release any is of this authori	formation regarding history, to zation shall be valid as the origi	eatment, disability, or benefits, b nal.	ut excluding genetic
TAND THE FOLLOWING: This form will be used for benefit information. The inf	ormation lister	above is correct and true. To v	erify incorrect information on th	is form is to commit fraud
the municipality on day law. This form will be used as an avid-structure to deduct		resume location (in any) to the co	sa un une penetits i nave selected	a sach Decarang
be punishable under law. This form will be used as an authorization to deduct at for myself or my dependents because of other group health coverage, I may,	in the future,	be able to enroll myself or my d	ependents in this plan. I must re	quest enrollment within 31
be punishable under law. This form will be used as an authorization to deduct	in the future, marriage, birth	h, adoption, or placement for ad	loption, I may be able to enroll m	yself or my dependents,

# W To Make Changes

# Unless you experience a Qualifying Event, changes to

- the plan cannot be made until the next open enrollment. If you experience a qualifying event, you have 31 days from the date of the event to make benefit changes. Changes are made via the <u>Enrollment - Change</u> <u>Form.</u>
- Qualifying events include:
  - Change with child's dependent status
  - Employment change
  - Change in coverage or eligibility under another plan



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**ST. AMBROSE** Financial Services, Inc.

ACTAL SURVICES, IN

# COVERAGE

# **Benefits become effective:**

### Open Enrollment

Effective beginning of plan year – January 1, 2024

#### □ New Employee

First day of the month following the first day of employment

#### Qualifying Event

Either the first day of the event or the first day of the month following the qualifying event, depending on termination date of coverage previously provided

#### □ Terminated employees

May continue coverage on a self pay basis as outlined in the Continuation of

Coverage section of the Summary of Plan Description

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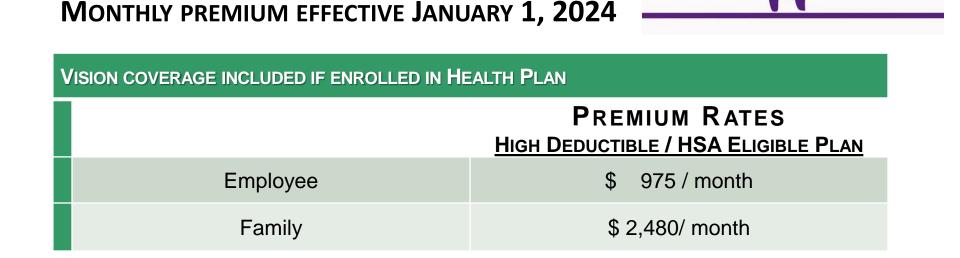
**FINANCIAL SERVICES, INC.** 

# **HIGH DEDUCTIBLE HEALTH PLAN / HSA**



Benefit	PPO	Non-PPO		
Deductible	Employee - \$2,200 Family - \$3,200 per individual \$4,200 per family	Employee - \$2,200 Family - \$3,200 per individual \$4,200 per family		
Co-Insurance	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket		
Maximum Out of Pocket	Employee - \$3,200 Family - \$6,200	Employee - \$5,200 Family - \$10,200		
Preventive / Wellness	Covered at 100% not subject to deductible	<ul><li>70% Insurance</li><li>30% Insured to maximum out of pocket</li></ul>		
Prescriptions /	Insured pays 20% after deductible to Maximum Out-of-Pocket	Insured pays 30% after deductible to Maximum Out-of-Pocket		
Pharmacy Plan	Insured pays full discounted price.			
Pre-Certifications	tifications Authorization required to cover hospitalization and other certain medical procedures least 72 hours prior for nonemergency admissions			

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**ST. AMBROSE** Financial Services, Inc.

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# PREMIUMS 2024

# TRADITIONAL DEDUCTIBLE HEALTH PLAN



Benefit	PPO	Non-PPO	
Deductible	Employee - \$1,000 Family - \$2,000	Employee - \$1,000 Family - \$2,000	
Co-Insurance	80% Insurance 20% Insured to maximum out of pocket	70% Insurance 30% Insured to maximum out of pocket	
Maximum Out of Pocket	Employee - \$2,000 Family - \$4,000	Employee - \$4,000 Family - \$8,000	
Preventive / Wellness	Covered at 100% not subject to deductible	<ul><li>70% Insurance</li><li>30% Insured to maximum out of pocket</li></ul>	
Prescriptions / Pharmacy Plan			
<b>Pre-Certifications</b>	Authorization required to cover hospitalization least 72 hours prior for nonemergency additional sectors and the sector of the s	ation and other certain medical procedures at missions	

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# TRADITIONAL DEDUCTIBLE HEALTH PLAN PREMIUMS 2024 MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024 VISION COVERAGE INCLUDED IF ENROLLED IN HEALTH PLAN

	PREMIUM RATES TRADITIONAL PLAN DEDUCTIBLE
Employee	\$ 1,406 / month
Family	\$ 3,573 / month

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# **PRESCRIPTIONS (PHARMACY BENEFIT)**

# Provider – CVS caremark



Listed on the Medical ID card which is presented when purchasing prescription drugs at participating pharmacies in your area. The Pharmacy Benefit is as follows:

#### Traditional Health Plan

- Retail purchases at a pharmacy for <u>generic prescriptions</u> 30% copayment of the total drug cost, with a minimum payment of \$10 per prescription, or actual total cost if less than \$10.
- Brand name prescriptions 30% copayment of the total drug cost.
- Prescription drug copayments are not applied to the plan deductible or coinsurance
- Maximum out of pocket of \$1,000 per person, up to \$3,000 per family, each plan year for copays

#### HDHP/HSA Plan

• Prescription drug copayments are applied to the plan deductible or coinsurance.

#### Mail Order option

- Approximately 80% of the prescription drugs currently used are maintenance drugs and typically can be purchased via the mail order option saves time and money.
- □ Check with provider to see if a generic equivalent is available for brand name/non-generic drugs.



# **COVERAGE SUMMARY – Delta Dental**

Deductible	Employee - Deductible = \$0 Employee + 1 dependent = \$0	\$1,500 - Maximum Benefit per participa	ant per plan year
	Family - Deductible = \$0 \$3,000 - Maximum Benefit per plan y		ar
Diagnostic & Preventative	Examinations, Bitewing X-rays, Teeth Cleaning 2 times per benefit year		100%
Preventive Charges			100%
Basic Dental	<ul> <li>Extractions &amp; other oral surgery</li> <li>Restorations - amalgam, composite (front teeth), stainless steel prefabricated crowns (1 per tooth in a 3-year period)</li> <li>Endodontics (root canal treatment &amp; therapy)</li> <li>Periodontics (treatment of gum)</li> <li>Repairs/adjustments to prosthetic appliances &amp; Dentures</li> <li>Anesthesia and Injections</li> <li>Emergency Palliative Treatment</li> </ul>		80%
Major Dental	dentures, or implants to repla	k, partial dentures, and complete ace missing permanent teeth on the six front teeth, bicuspids and	50%





MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

# PREMIUM RATES

Employee Only	\$ 39
Employee plus 1	\$ 76
Employee plus 2 or more (Family)	\$ 126

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**ST. AMBROSE** FINANCIAL SERVICES, INC.





BENEFIT	DESCRIPTION	COPAY	FREQUENCY
	Your Coverage with a VSP Provider		
WELLVISION EXAM	<ul> <li>Focuses on your eyes and overall wellness</li> <li>Routine retinal screening</li> </ul>	\$10 Up to \$39	Every 12 months
ESSENTIAL MEDICAL EYE CARE	<ul> <li>Retinal imaging for members with diabetes covered-in-full</li> <li>Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more.</li> <li>Coordination with your medical coverage may apply. Ask your VSP network doctor for details.</li> </ul>	\$20 per exam	Available as needed
PRESCRIPTION GLASSE	ES	\$25	See frame and lenses
FRAME.	<ul> <li>\$220 Featured Frame Brands allowance</li> <li>\$200 frame allowance</li> <li>20% savings on the amount over your allowance</li> <li>\$200 Walmart/Sam's Club frame allowance</li> <li>\$110 Costco frame allowance</li> </ul>	Included in Prescription Glasses	Every 24 months
LENSES	<ul> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Impact-resistant lenses for dependent children</li> </ul>	Included in Prescription Glasses	Every 12 months
LENS ENHANCEMENTS	<ul> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 30% on other lens enhancements</li> </ul>	\$0 \$95 - \$105 \$150 - \$175	Every 12 months
CONTACTS (INSTEAD OF GLASSES)	<ul> <li>\$130 allowance for contacts; copay does not apply</li> <li>Contact lens exam (fitting and evaluation)</li> </ul>	Up to \$60	Every 12 months
VSP LIGHTCARE**	<ul> <li>\$200 allowance for ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts</li> </ul>	\$25	Every 24 months
ADDITIONAL SAVINGS	Glasses and Sunglasses         • Extra \$20 to spend on Featured Frame Brands. Go to vsp.com/o         • 20% savings on unlimited additional pairs of prescription or non- lens enhancements, from a VSP provider within 12 months of you         Laser Vision Correction         • Average of 15% off the regular price; discounts available at contra Exclusive Member Extras for VSP Members         • Contact lens rebates, lens satisfaction guarantees, and more offe	prescription glass r last WellVision E acted facilities.	Exam.
	<ul> <li>Save up to 60% on digital hearing aids with TruHearing<sup>®</sup>. Visit vsg details.</li> <li>Enjoy everyday savings on health, wellness, and more with VSP S</li> </ul>	.com/offers/spec	

With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to vsp.com to find an in-network provider.







MONTHLY PREMIUM EFFECTIVE JANUARY 1, 2024

PREMIUM RATES	
Employee Only	\$ 4.95
Family	\$ 11.82

# NOTE:

- The Vision Insurance premium is included at no added cost for employees enrolled in the Diocese of La Crosse Lay Group Employee Health Plan
- Family Vision is available as a stand-alone benefit. You can elect Employee Only Health and Family Vision, or you can elect Vision without any Health benefit.

The information provided is an outline of the benefits and guidelines of the Diocese of La Crosse Lay Group Employee Medical Benefit Plan and is not intended to be all inclusive. For more information, visit <u>www.StAmbroseFinancial.com</u> – Health Plan - Lay Group.

# PREMIUMS 2024 SUMMARY

# MONTHLY PREMIUMS EFFECTIVE JANUARY 1, 2024

HDHP / HSA (VISION COVERAGE INCLUE	(VISION COVERAGE INCLUDED IN PLAN)		
Employee	\$	975	
Family	\$	2,480	

Т	TRADITIONAL (VISION COVERAGE INCLUDED IN PLAN)			
	Employee	\$	1,406	
	Family	\$	3,573	

DENTAL	
Employee	\$ 39
Employee plus 1	\$ 76
Family	\$ 126

VISION (VOLUNTARY)		
	Employee	\$ 4.95
	Family	\$ 11.82

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# **BASIC LIFE**



# Group Life

	<ul> <li>Enrollment must take place within 31 days following the first day of work with employer within the Diocese of La Crosse</li> <li>Full-time teacher or other teacher working at least 30 hours per week during the school year (1,140 annual hours)</li> </ul>	
Eligibility	<ul> <li>A non-teacher, school-year Employee working at least 30 hours per week during the school year (1,140 annual hours)</li> </ul>	
	<ul> <li>All other Employees working at least 30 hours per week for 50 weeks per year (1,500 annual hours)</li> </ul>	
	Late Enrollees must complete Evidence of Insurability and are subject to approval. Coverage is effective upon approval.	
Death Benefit	\$30,000	
Accidental Death and Dismemberment Benefit	\$30,000	

Basic Life monthly premium - \$3.90 per month, typically paid by the employer.

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**ST. AMBROSE** FINANCIAL SERVICES, INC.

# **VOLUNTARY LIFE**



Eligibility	Employees who work at least 20 hours per week
Benefits	Life insurance in \$10,000 increments up to \$500,000 (not to exceed 5 times annual income). Non- medical maximum of \$150,000. If coverage is selected, employee can choose coverage for spouse and/or dependent child(ren) up to age 18 (23 if a full-time student). Coverage for spouses is in \$5,000 increments up to \$100,000 (not to exceed 50% of the employee election), non-medical maximum of \$25,000. Coverage for dependent child(ren) is in increments of \$2,500, \$5,000, \$7,500, or \$10,000, without medical underwriting.
Costs	Monthly premium charges depend on age and benefit amount elected. Premiums are paid by the employee.
Can I be turned down?	If enrolled when first eligible, employee and dependents can be covered for up to the non-medical (guarantee issue) maximum listed without medical questions, provided the eligibility requirements listed above are met.
When Can I Enroll?	Enrollment must take place within 31 days following the first day of work in a position which meets the eligibility requirements. This includes a change in scheduled hours to a position that would meet eligibility requirements. Late enrollees will be required to wait until the next annual enrollment to apply and will be subject to medical review and could be turned down by the insurance company.
Coverage Effective Date	Coverage will be effective the first of the month following the first day of work. Late enrollees will be effective on the first of the month following approval by the carrier's underwriting department

# **VOLUNTARY LONG-TERM DISABILITY**



Eligibility	Employees who work at least 20 hours per week
Benefits	You can receive up to 60% of your gross income if you become disabled due to a sickness or injury, on or off the job. Benefits begin after 90 days of disability and can last until age 65 or beyond.
Costs	Monthly premium charges vary depending on your age and income. Premiums are paid entirely by the employee. You will receive a summary of benefits with information on rates and how to calculate monthly premiums.
Can I be turned down?	If you enroll when first eligible, you cannot be turned down regardless of your health, as long as you meet the eligibility requirements listed above.
When Can I Enroll?	Enrollment for the voluntary long term disability insurance must take place within 31 days following the first day of work in a position which meets the eligibility requirements. This includes a change in scheduled hours to a position that would meet eligibility requirements. Late enrollees will need to wait until the next open enrollment to apply and will be subject to medical review and could be turned down by the insurance company.
Coverage Effective Date	Coverage will be effective the first of the month following the first day of work. Late enrollees will be effective on the first of the month following approval by the carrier's underwriting department

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# **ST. AMBROSE**

FINANCIAL SERVICES, INC.



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